STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155747	A. BUILDING 01 B. WING	08/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING CENTER	1300 MERCER AVE DECATUR, IN46733

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/08/11 Facility Number: 000556 Provider Number: 155747 AIM Number: 100290130 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Woodcrest Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully	K0000	Attached is Woodcrest's Plan of Correction for our annual Life Safety survey conducted on August 8, 2011.The attached plan of correction is our credible allegation of compliance.Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admission or agreement by Woodcrest of the facts alleged or conclusions set forth in the statement of deficiencies. Ths plan of correction and specific corrective actions are preapared and/or executed incompliance with Life Safety Code.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and resident rooms. The facility has a capacity of 143 and had a census of 116 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/10/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 roll down doors at	K0029	1. Whati corrective action(s) will be accomplished fior tihose residentis fiound tio have been afiectied by tihe deficienti practice?	09/19/2011

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	the openings in the kitchen wall, a hazardous area, would self close upon activation of the fire alarm system. This deficient practice could affect all residents in the main hall dining room. Findings include: Based on observation with Maintenance Technician # 1, Maintenance Technician # 2, Maintenance Lead and the Environmental Service Supervisor on 08/08/11 at 1:35 p.m., the main dining room was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall around the dining room is therefore, considered to be the corridor wall. There was a pass through opening in the corridor wall between the dining room and the kitchen. The opening was protected with a rolling door. Based on interview with Maintenance Director at the time of observation, the rolling door does not close upon activation of the fire alarm. 3.1-19(b)		In an efiorti tio correcti tihis deficienti practice, tihe pass tihrough opening in tihe corridor wall betiween tihe dining room and tihe kitichen will have tihe rolling door connectied tio tihe fire panel so tihe rolling door will close upon activation ofi tihe fire alarm. 2. How otiher residentis having tihe potiential tio be afiectied by tihe same deficienti practice will be identified and whati corrective action(s) will be tiaken? In an efiorti tio preventi residentis firom being afiectied by tihis deficienti practice, tihe deficienti practice has been correctied by connecting tiherolling door tio tihe fire panel There are no otiher pass tihrough doors in tihe fiacilitiy 3. Whati measures will be puti intio place or whati systiemic changes will be make tio ensure tihati tihe deficienti practice does noti recur? The deficienti practice cannoti recur as tihe pass tihrough rolling door has been connectied tio tihe fire panel and tihere are no otiher pass tihrough rolling doors in tihe fiacilitiy 4. How tihe corrective action(s) will be monitiored tio ensure tihe deficienti practice will noti recur, whati qualitiy assurance programs will be puti intio place? Fire drills are held montihly and closure ofi tihe pass tihrough door will be monitiored by tihe maintienance	

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			man montihly tio ensure closure ofi tihe door when tihe fire alarm is activatied Monitioring will be ongoing witih resultis tio QA timeS monthis	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure exit access was arranged so 2 of 7 exits were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.7.1 requires all exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. In addition to providing the required width to allow all occupants safe access to a public way, such access also needs to meet the requirements with respect to maintaining the means of egress free of obstructions that would prevent its use, such as snow and the need	K0038	1. Whati corrective action(s) will be accomplished fior tihose residenti fiound tio have been afiectied by tihe deficienti practice? In an efiorti tio correcti tihis deficienti practice, tiemporary sidewalks have been instialled leading tio a public way firom tihe A and C wing 2. How otiher residentis having tihe potiential tio be afiectied by tihe same deficienti practice will be identified and whati corrective action(s) will be tiaken? No residentis will be afiectied by tihis deficienti practice as tiemporary walkways are in place leading tio a public way and will be replaced witih permanenti walkways witihin60 days. 3. Whati measures will be puti intio place or whati systiemic changes will be make tio ensure tihati tihe deficienti practice does noti recur? Temporary walkways have been instialled and will be replaced witih permanenti walkway leading tio tihe public way witihin60 days ensuring tihis deficienti practice does noti recur. 4. How tihe corrective action(s) will be monitiored tio ensure	08/23/2011

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	for its removal in some climates or soft ground during heavy periods of rain. This deficient practice could affects all occupants evacuated through the exits at the end of both A and C wings. Findings include: Based on an observation with Maintenance Technician # 1, Maintenance Technician # 2, Maintenance Lead and the Environmental Service Supervisor on 08/08/11 at 12:15 p.m. and then again at 12:55 p.m., due to the construction of a new rehabilitation wing, the sidewalk was removed from the egress path at the exit at the end of both A and C wings. The excavation of this area has created large mounds of dirt and holes. The distance from the public way to A wing sidewalk is one hundred feet. The distance from C wing is sixty feet. Measurements were provided by Maintenance Technician # 1 at the time of observations. 3.1-19(b)		tihe deficienti practice will noti recur whati qualitiy assurance programs will be puti intio place No monitioring needed as sidewalks tio public ways are permanenti once instialled	

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K0045 SS=E	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to ensure the failure of any single fixture or bulb would not leave the area in darkness at 2 of 7 exits. This deficient practice could affect any number of residents, staff and visitors evacuated using the exits located at the end of wings A and C in the event of an emergency. Finding include: Based on an observation with Maintenance Technician # 1, Maintenance Technician # 2, Maintenance Lead and the Environmental Service Supervisor on 08/08/11 at 12:20 p.m. and then again at 12:57 p.m., the exterior exit discharge for wings A and C was equipped with a single light fixture with a single bulb. Based on an interview with Maintenance Technician # 1 at the time of observation, additional lights for these exit discharge	K0045	1. Whati corrective action(s) will be accomplished fior tihose residentis fiound tio have been afiectied by tihe deficienti practice? In an efiorti tio preventi residentis firom being afiectied by tihis deficienti practice, constiruction lightisconnectied tio tihe generatior will be tiemporarily used fior approximatiely60 days equal tio one fiooti candle tio preventi areas ofi darkness along tihe walkways firom A and C wing leading tio tihe public way. 2. How otiher residentis having tihe potiential tio be afiectied by tihe same deficienti practice will be identified and whati corrective action(s) will be tiaken? No residenti has tihe potiential tio be afiectied by tihis deficienti practice as walkways have been liti and no otiher walkways were afiectied by tihe constiruction projecti 3. How otiher residentis having tihe potiential tio be afiectied by tihe same deficienti practice will be identified and whati corrective action(s) will be tiaken? The constiruction lightis are hooked tio tihe generatior and tihe permanenti lighting will be connectied tio tihe generatior whichis selfi tiestied weekly	08/23/2011

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	paths were located in the parking lot but due to the addition of the Rehabilitation wing the parking lot and lights were removed in the excavation process. 3.1-19(b)		with fiull load montihly How tihe corrective actior(s) will be monitiored tio ensure tihe deficienti practice will noti recur, whati qualitiy assurance programs will be puti intio place? The generator is self tested weekly to ensure lights are operating even with loss of power. Documentation will be done by the maintenance man monthly and results to QA times 7 months.	
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure 1 of 6 water heaters had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of residents. This deficient practice could affect any resident near the B wing mechanical room. Findings include: Based on record review with Maintenance Technician # 1, Maintenance Technician # 2, Maintenance Lead and the	K0130	1. Whati corrective action(s) will be accomplished fior tihose residensti fiound tio have been afiectied by tihe deficienti practice? In an efiorti tio preventi tihis deficienti practice firom afiecting residentis, tihe watier heatiers were inspectied on Augusti17 tio ensure safie operating condition. 2. How otiher residentis having tihe potiential tio be afiectied by tihe same deficienti practice will be identified and whati corrective action(s) will be tiaken? In an efiorti tio preventi residentis tio be afiectied by tihis deficienti practice all watier heatiers were inspectied tio ensure safie operating condition Inspections are currenti in tihe nursing fiacilitiy and maintienace is awaiting tihe certificatie tio be emailed. 3. How tihe corrective action(s) will be monitiored tio ensure	08/26/2011

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	Environmental Service Supervisor on 08/04/11 at 12:35 p.m., the B wing mechanical room water heater with registration tag number 260343 had a Certificate of Inspection which expired on 05/26/11. Based on an interview with the Maintenance Technician # 1 at the time of record review, he was unable to provide a current certificate for this water heater. 3.1-19(b)		tihe deficienti practice will noti recur whati qualitiy assurance programs will be puti intio place? **In an eforti tio preventi tihis defcienti practice from recurring, tihe watier heatiers were placed on tihe PM schedule.** 4. How tihe corrective action(s) will be monitiored tio ensure tihe deficienti practice will noti recur whati qualitiy assurance programs will be puti intio place? **The PM schedule will be monitiored montihly by tihe lead maintienance man tio ensure tihe watier heatiers are inspectied and tihecertifcatie indicaties currenti inspection daties This QA will be ongoing witih resultis tio QA times7 montihs**	